NEW YORK MEDICAL COLLEGE

LEAVE REPORT ADJUSTMENT FORM

Name: _____

Employee #: _____

Department: _____

TYPE OF CHANGE:	**FROM:**	**TO:**	**PAY PERIOD:**
[ ] Vacation Carryover	_____	_____	_____
[ ] Vacation Taken	_____	_____	_____
[ ] Vacation Accrual	_____	_____	_____
[ ] Sick Days Taken	_____	_____	_____
[ ] Sick Accrued	_____	_____	_____
[ ] Personal Taken	_____	_____	_____
[ ] Personal Earned	_____	_____	_____
[ ] Other	_____	_____	_____

Reason for change: _____

_____

_____ _____

Department Administrators Signature **Date**

_____ _____

Employee Signature **Date**

Please send the completed form to Tom Darcy, Human Resources Department

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For Human Resources Use Only

_____ _____

Verified by **Input on**